

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **34807**
Registrar's No. **73**

FILED NOV 3 1952

BIRTH NO. _____		REG. DIST. NO. 139		PRIMARY REG. DIST. NO. 5541		Registrar's No. 73	
1. PLACE OF DEATH a. COUNTY HOLT				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE IOWA b. COUNTY WOODBURY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL UNION TWP.		c. LENGTH OF STAY (in this place) 2 WKS.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SLOAN		8140	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3 mi west of Bigelow				d. STREET ADDRESS (If rural, give location) 0			
3. NAME OF DECEASED (Type or Print) FRANK		a. (First)		b. (Middle)		c. (Last) BARINGER	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH 9/29/1890	
9. AGE (In years last birthday) 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN		11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME NIMROD BARINGER		13b. MOTHER'S MAIDEN NAME REBECCA COONES		14. NAME OF HUSBAND OR WIFE FRIEDA BARINGER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 481-16-7231		17. INFORMANT'S SIGNATURE OR NAME MRS. FRIEDA BARINGER		ADDRESS SLOAN, IOWA	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION 4201			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from Oct 30, 1952 to Oct 30, 1952 , that I last saw the deceased alive on Oct 30, 1952 , and that death occurred at 8 a. m. , from the causes and on the date stated above.							
23a. SIGNATURE D. P. Perry M.D. (Degree or title)				23b. ADDRESS Mound City Mo		23c. DATE SIGNED 10-30-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 10/30/52		24c. NAME OF CEMETERY OR CREMATORY SLOAN TWP. Cem.		24d. LOCATION (City, town, or county) (State) NEAR SLOAN, IOWA	
DATE REC'D BY LOCAL REG. 10/30/1952		REGISTRAR'S SIGNATURE James H. Crawford		25. FUNERAL DIRECTOR'S SIGNATURE James H. Crawford		ADDRESS Thousand City, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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DEC 9 1952

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Student Embalmer No.

Signed

James H. Crawford

Signed.....
Student Embalmer

Licensed Embalmer No. *4796*

P. O. Address *Marion City, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.